

SERFF Tracking Number:	TRST-127171261	State:	Arkansas
Filing Company:	Trustmark Life Insurance Company	State Tracking Number:	48789
Company Tracking Number:	11.00177		
TOI:	H12 Health - Excess/Stop Loss	Sub-TOI:	H12.004 Self-Funded Health Plan
Product Name:	SL-0601 APP AR R05-11		
Project Name/Number:	Stop Loss Application/11.00177		

Filing at a Glance

Company: Trustmark Life Insurance Company

Product Name: SL-0601 APP AR R05-11

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Filing Type: Form

SERFF Tr Num: TRST-127171261 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 48789

Co Tr Num: 11.00177

State Status: Approved-Closed

Author: Jeri Jacks

Date Submitted: 05/16/2011

Reviewer(s): Rosalind Minor

Disposition Date: 06/02/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Stop Loss Application

Project Number: 11.00177

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 06/02/2011

State Status Changed: 06/02/2011

Created By: Jeri Jacks

Corresponding Filing Tracking Number:

Filing Description:

Arkansas Department of Insurance

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed in IL.

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Lisa Sayerstad

RE: FEIN: 36-3421358; NAIC: 276-62863

Trustmark Life Insurance Company

Stop Loss (Excess Loss) Insurance

Application: SL-0601 APP NM R05-11

Our File No: 11.00177

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Dear Sir or Madam:

The above-outlined form is being submitted for review and approval for use in your state. This form is new and will not replace any existing form(s).

This application will be used with stop loss form SL-0601 AR R12-05, previously approved on 11/17/05 under our filing number 5.03647.

Because stop loss contracts are custom designed and contain variable options, we have submitted the application forms with bracketed text or numbers. The brackets indicate material that may change based on options elected by the employers, marketing philosophy, or changes in state law. Variable material will always meet the minimum requirement of your state's laws.

The forms are in final printed format as issued from a laser printer. However, we use different computer publishing systems. Therefore, actual issued forms may have a different font style than the submitted forms. As a result, page breaks may occur at different lines and line wording may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate re-filing for such font style variation.

If you have any questions or concerns about this filing, please contact me at (800) 666-6977, extension 34205 or at jjacks@trustmarkins.com.

Sincerely,

Jeri K. Jacks
Compliance Analyst
Law Department

Company and Contact

Filing Contact Information

Jeri Jacks, Regulatory Advocacy Analyst
400 Field Drive
Lake Forest, IL 60045

jjacks@trustmarkins.com
800-666-6977 [Phone] 34205 [Ext]
847-615-3872 [FAX]

Filing Company Information

Trustmark Life Insurance Company

CoCode: 62863

State of Domicile: Illinois

<i>SERFF Tracking Number:</i>	<i>TRST-127171261</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Project Name/Number:</i>	<i>Stop Loss Application/11.00177</i>		
400 Field Drive	Group Code: 276	Company Type:	
Lake Forest, IL 60045	Group Name:	State ID Number:	
(800) 666-6977 ext. [Phone]	FEIN Number: 36-3421358		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	The fee for a form in Illinois is \$50 per form, so the fee would be \$50.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Trustmark Life Insurance Company	\$50.00	05/16/2011	47661140

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/02/2011	06/02/2011

<i>SERFF Tracking Number:</i>	<i>TRST-127171261</i>	<i>State:</i>	<i>Arkansas</i>
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Disposition

Disposition Date: 06/02/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>TRST-127171261</i>	<i>State:</i>	<i>Arkansas</i>
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	No
Supporting Document	Flesch Certification	Approved-Closed	No
Form	Stop Loss Application	Approved-Closed	No

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Form Schedule

Lead Form Number: SL-0601 APP AR R05-11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Status							
Approved-	SL-0601	Application/	Stop Loss	Initial			SL-0601 APP
Closed	APP AR	Enrollment	Application				R05-11 AR
06/02/2011	R05-11	Form					Final (2).pdf

TRUSTMARK LIFE INSURANCE COMPANY
Application for Stop Loss [and Ancillary] Insurance Coverage

[Application is hereby made to Trustmark Life Insurance Company ("Company") for [Aggregate] [and] [Specific] Stop Loss Insurance]. [Application may also include ancillary coverage as indicated on the proposal.] This Application must be accepted and approved by the Company prior to any Contract being in effect.]

[Attach a copy of the proposal indicating the employer's plan selection(s) with this application.]

[1.] [Full Legal name of [Employer/Policyholder/Applicant]] _____

[2.] [Key contact at [Employer/Policyholder]] _____

[3.] [Company Plan Administrator (Name and Title)] _____

[Phone number:] _____ [Fax Number:] _____

[E-mail Address:] _____

[4.] [Address] _____

[5.] [City, State, ZIP Code] _____

[6.] [Subsidiary or affiliated companies (companies under common control through stock ownership, contract or otherwise) that are to be included. List legal names and addresses of such companies.]

[7.] **[Persons to be covered under the Stop Loss Contract:** Employees and dependents who meet the eligibility requirements as set forth under the [Employer/Policyholder]'s underlying Plan, except an employee or dependent who satisfies a description indicated in Item Numbers 1, through 7 of the Stop Loss Disclosure Statement, completed on behalf, and signed by a duly authorized officer of the [Employer/Policyholder], unless named on the Stop Loss Disclosure Statement and approved by Trustmark.]

[8.] [Other locations. Include city, state and ZIP code.]

[9.] [Name of UR Provider and/or PPO Organization(s).]

[10.] [Nature of [Employer/Policyholder]'s Business] [and Date Business Started.]

☐ [Corporation] ☐ [Partnership] ☐ [Proprietorship] ☐ [Other] _____

[11.] [Has the [Employer/Policyholder] ever voluntarily applied for relief in the Bankruptcy Court?

☐ Yes ☐ No If yes, explain]

[12.] [Enter the full name of your Employee Benefit Plan]

[13.] [Name and address of [Employer/Policyholder]'s Third Party Administrator]

[14.] [Number of **full-time and part-time** employees:]

[15.] [Number of **full-time** employees:]

[16.] [Number of employees covered under or in election period of COBRA or state continuation:_____]

[17.] [Number of employees in their **waiting period**:]

[NOTE: Any employees who in their waiting period and eligible for coverage within 60 days of the group's effective date must submit a completed Employee Eligibility Statement.]

[18.] [Eligible employees will be insured the first day of the month following [_____] days of continuous employment (waiting period).]

☐ Waive the waiting period for all employees during the initial enrollment

[19.] [Carve Out?] ☐ Yes ☐ No

If "yes", indicate the class to be covered _____

[20.] [**Prior Coverage:**]

[Is prior group medical coverage?]☐ _____ ☐ fully insured ☐ self-funded

[Name of prior group medical carrier:]_____ [In effect since:]_____

[Name of prior group dental carrier:]_____ [In effect since:]_____

[Why are you leaving your current group carrier?]

[Premium renewal date with current group carrier?]

[Attach a copy of the most recent billing statement(s) from your prior carrier(s).]

[21.] [Retirees covered?] ☐ Yes ☐ No

[22.] [**Contribution:**]

[Employer Contribution: Employer may contribute toward the health coverage.]

[Employer contribution for employees:_____% Employer contribution for dependents_____%]

[Please note: [Employer/Policyholder]'s Third Party Administrator must complete and submit a - Trustmark Stop Loss Administrator Application. Trustmark shall rely on such application in underwriting [Employer/Policyholder]'s application for Stop Loss Insurance coverage. Should subsequent information about the [Employer/Policyholder]'s Third Party Administrator's controls and processes become known, which, if known prior to underwriting this application was material because it would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of Coverage by providing notice to you.]

1. [Proposed Effective Date] _____
2. [Total eligible employees] _____ [Estimated initial enrollment] _____
3. [Deposit premium]\$ _____

[GENERAL SCHEDULE OPTIONS]

[A. Aggregate Stop Loss ☐ Yes ☐ No]

[Benefit Period: Eligible [Employer/Policyholder] Losses from Plan expense

Incurred from _____ through _____,
and

Paid from _____ through _____.]

[Losses Incurred prior to the Effective Date will be limited to the amount as set forth in the Schedule of Stop Loss.]

[Coverages applying to Aggregate Stop Loss include (not included unless checked):]

- ☐ [Medical] ☐ [Prescription Drug Card Program]
☐ [Dental Care] ☐ [Mail Order Prescription Drug Card Program]
☐ [Vision Care] ☐ [Weekly (Disability) Income]
☐ [Other] _____

[Aggregate Percentage Reimbursable (excess of Attachment Point) _____%]

[Maximum Aggregate Benefit, excess of Annual Aggregate Attachment Point, per Benefit Period
\$ _____]

[Maximum Employee Benefit Plan Losses per Covered Person per Benefit Period
\$ _____]

[Monthly Aggregate Accommodation ☐ Yes ☐ No]

[Aggregate Terminal Liability Protection ☐ Yes ☐ No]

[B. Specific Stop Loss ☐ Yes ☐ No]

[Benefit Period: Eligible [Employer/Policyholder] Losses from Plan expenses

Incurred from _____ through _____, and

Paid from _____ through _____.]

[Losses Incurred Prior to the Effective Date will be limited to the amount reimbursable as set forth in the Schedule of Stop Loss.]

[Eligible expenses for Specific Stop Loss include:

- ☒ [Medical] ☐ [Prescription Drug Card Program]
☐ [Dental Care] ☐ [Mail Order Prescription Drug Card Program]
☐ [Vision Care] ☐ [Weekly (Disability) Income]
☐ [Other]

[Specific Deductible (per person)\$_____]

[Specific Percentage Reimbursable (excess of deductible) _____%]

[Lifetime Maximum Specific Benefit \$_____
(per person in excess of Specific Deductible)]

[RISK ASSUMPTIONS]

[Active Employees and Dependents:]

[The Company will rely on the data included in this application to assist in underwriting the [Employer/Policyholder] for Insurance. The Employee Eligibility Statement is made part of this application for insurance and shall be relied upon in determining rates and eligibility for coverage. [Note, that without Company review and consent in writing of each individual risk in the categories listed below, the participating [Employer/Policyholder]'s Losses will not be reimbursable under the Stop Loss Insurance Contract.]]

1. [Eligible persons provided with health care during the last [twelve] months where the expenses for health care exceeded or are expected to exceed \$ _____;]
2. [Eligible persons with health conditions which have the potential to exceed \$ _____ in the next [twelve] months;]
3. [Eligible persons currently hospital or institution confined, or expected to be confined within [90 days] of the effective date;]
4. [Eligible persons who have had an organ or bone marrow transplant, or who have been evaluated for, or accepted into a transplant program;]
5. [Eligible persons who opt out of coverage under the [Employer/Policyholder]'s underlying Plan for any reason.]

[Please list all individuals who fall into any of the categories listed above and attach a completed Disclosure Statement listing all of these individuals.]

(Question 5, continued)

[Please attach additional pages if needed.]

[Disabled and Continuing Employees and Dependents:]

[Are extended benefits available from the prior insurer for presently disabled eligible employees and/or their dependents? ☐ Yes ☐ No]

[Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? ☐ Yes ☐ No]

[Will any former employee or dependent be continuing coverage under the Plan in accordance with federal, state or local law on the effective date of this Contract? ☐ Yes ☐ No]

[If the answer is yes to any of the above three questions, please explain.]

[The [Employer/Policyholder]'s Losses from Plan benefits for any Employee who is not at his customary place of employment (or scheduled vacation) and any dependent, COBRA beneficiary, retiree and any Covered Person who is on Social Security disability continuance or any other leave of absence who is confined in a medical facility on the [Employer/Policyholder]'s Effective Date, will not be eligible for reimbursement under the Stop Loss Insurance Contract until:

- an employee returns to active, full-time work at his customary place of employment for at least one complete work day, performing all of the normal job duties required and expected of his position; or
- a dependent or continuation beneficiary is discharged from the medical facility of confinement.]

[If a Covered Person's health care coverage under the Plan is being continued in accordance with federal, state or local legislation on the [Employer/Policyholder]'s Stop Loss Insurance Contract effective date, his claims will not apply towards any Stop Loss Insurance deductibles or factors unless specifically agreed upon by the Company in writing.]

[The [Employer/Policyholder] hereby requests that the claims under the Plan for the following disabled persons and those individuals being continued in accordance with federal, state or local legislation be considered under the Stop Loss Contract. The [Employer/Policyholder] understands that the Company will evaluate the risk involved and may allow consideration of the following person's claims under the Stop Loss Insurance Contract by an adjustment in rates and or limitations placed upon such claims. The Company will provide the [Employer/Policyholder] specific written notification of its decision.]

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[The individuals listed above must be included on the Disclosure Statement.]

[GENERAL CONDITIONS]

[It is understood and agreed as conditions precedent to the approval of this Application that:

- [The [Employer/Policyholder] is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;]
- [The Third Party Administrator retained by the [Employer/Policyholder] will be considered the [Employer/Policyholder]'s Agent and not the Company's Agent;]
- [All documentation[including the Employee Eligibility Statement] requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within [thirty (30) days] of the Effective Date;]
- [The Company will evaluate the [Employer/Policyholder]'s risk, and may require adjustments of rates, factors and or special limitations to accommodate for abnormal risks;]
- [Premiums are not considered paid until the premium check is received by the Company and at the rates set forth in the Schedule of Stop Loss.]
- [If the [Employer/Policyholder] has more than one business location, a representative of the [Employer/Policyholder] at each location has reviewed and completed the Risk Assumption section of this application and appropriate responses on the Disclosure Statement.]

[In making this application, the [Employer/Policyholder] represents that such information accurately reflects the true facts and that the undersigned has authority to bind the [Employer/Policyholder] to the proposed Contract. Accordingly, this request will be a part of the Contract if accepted by the Company.]

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Any person who knowingly presents a false or fraudulent claim for payment of loss or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[Dated at _____ this ____ day of _____, [2007]]

[Employer/Policyholder] _____
Type or Print

[Authorized Office/Partner] _____

[Title] _____

[Tax ID #] _____

[Witness:] _____

[Writing agent or broker of [Employer/Policyholder]] _____

Please Print

[Writing agent or broker of [Employer/Policyholder]] _____

Signature

[Social Security No. Or Tax ID] _____

[Address]

[Where is the Contract and other correspondence to be mailed?] _____

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Supporting Document Schedules

		Item Status:	Status
			Date:
Bypassed - Item:	Application	Approved-Closed	06/02/2011
Bypass Reason:	Not applicable; this is the filing of an application.		
Comments:			

		Item Status:	Status
			Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/02/2011
Comments:			
Attachment:			
AR Flesch.pdf			

Trustmark

Insurance Companies

Law Department

Phone 847.615.1500

Fax 847.615.3872

This is to certify the forms shown below comply with the requirements of Arkansas Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch reading ease score as follows:

Form

Flesch Score

SL-0601 APP AR R05-11

44

Sandra

Przybyszewski

Digitally signed by Sandra
Przybyszewski
DN: cn=Sandra Przybyszewski, c=US
Date: 2011.05.16 16:00:18 -05'00'

Sandra Przybyszewski
Vice President

ARKANSAS

Trustmark Life Insurance Company • Trustmark Insurance Company

400 Field Drive • Lake Forest, Illinois 60045